ILLINOIS WORKERS' COMPENSATION COMMISSION
APPLICATION FOR SELF-INSURANCE
FOR SUBSIDIARY OR AFFILIATE

Read all instructions before completing this application. Answer all questions.

RETURN TO:	APPLICANT'S LEGAL NAME/MAILING ADDRESS/WEB SITE	DESIRED SELF-INSURANCE EFFECTIVE DATE:
Office of Self-Insurance Admin. 701 S. Second St. Springfield, IL 62704	SUBSIDIARY ☐ AFFILIATE ☐	

The employer (applicant) applies for the privilege of being a certified self-insurer in the State of Illinois, as provided in the Illinois Workers' Compensation and Occupational Diseases Acts. An applicant may not operate as a certified self-insurer until the Commission issues a *Certificate of Approval to Self-Insure*.

1. LIST THE COMPANY REPRESENTATIVE FOR SELF-INSURANCE.

Name		Title	
Company name			
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

2. APPLICANT'S FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	
3. STATUS:	Individual ☐ Partnership ☐ Corporation ☐
4. NATURE OF BUSINESS	

Primary NAICS codes				

NAICS = North American Industry Classification System, which replaces SIC.

5. INCORPORATED OR ORGANIZED UNDER THE LAWS OF THE STATE OF		ON	
6. DATE OF COMMENCEMENT OF BUSINESS IN ILLINOIS			
7. EXACT LEGAL NAME OF ULTIMATE PARENT			
FEIN		Web site address	

8. LIST THE PHYSICAL LOCATIONS OF EACH OPERATION TO BE SELF-INSURED. *If attaching a list, follow the same format.*

OPERATION NAME AND ADDRESS	FEIN	NAICS CODE	NATURE OF BUSINESS	AVERAGE # OF EMPLOYEES IN	
				PRODUCTION	OFFICE/SALES

9. LIST THE NAME OF THE CURRENT WORKERS' COMPENSATION INSURANCE CARRIER.

Name					
Policy number		Effective dates: From		to	

Provide evidence of applicant's current workers' compensation coverage.

10. INDICATE THE ESTIMATED ANNUAL WORKERS' COMPENSATION PREMIUM FOR THE LAST COMPLETED CALENDAR YEAR. *If necessary, attach a list.*

INSURANCE CLASS CODE	INSURANCE CLASSIFICATION DESCRIPTION	# EMPLOYEES	EST. ANNUAL PAYROLL	CURRENT MANUAL RATE	EST. ANNUAL PREMIUM
TOTAL					

11. PROVIDE THE FOLLOWING CLAIMS INFORMATION FOR YOUR PROPOSED SELF-INSURED OPERATIONS IN ILLINOIS FOR THE LAST THREE COMPLETED YEARS. *Attach detailed loss runs for the last three completed years.*

	YEAR ENDING	YEAR ENDING	YEAR ENDING
A. Number of accidents requiring only medical attention			
B. Number of accidents requiring lost time of more than 3 days			
C. Total paid claims			
D. Outstanding reserves (incl. medical, indemnity, & expenses) *If the reserves vary by more than 20% during these years, provide an explanation.*			
E. Total incurred losses (paid and reserves)			
F. Number of fatalities			

Attach a description of each fatality, including the employee's name, date of accident, cause of accident, current status of the claim, and the outcome of any OSHA investigation and/or citations relating to the fatality.

12. LIST THE DESIGNATED SAFETY REPRESENTATIVE.			
Name		Title	
Street address			
City/State/Zip			
Telephone		Fax	
E-mail address			

Attach a narrative description of the safety and loss control program components for your operations in Illinois. Do not send a manual.

13. WHAT MEDICAL FACILITIES ARE AVAILABLE TO YOUR EMPLOYEES? First aid ☐ In-plant doctor/nurse ☐ Local clinic ☐ Hospital ☐ Other ☐ (please explain)

14. IF ANY OF THE APPLICANT'S EMPLOYEES HAVE EXPOSURE IN ANY DEGREE TO SUBSTANCES THAT MAY CAUSE OCCUPATIONAL DISEASE, INDICATE THE SUBSTANCE AND APPROXIMATE PERCENTAGE OF EMPLOYEES EXPOSED. *If necessary, attach a list. Include asbestos, silica dusts, any toxic, injurious, or hazardous substances, compounds, or chemicals, caustics, fumes, noise, radiation, communicable diseases, and any other occupational disease exposures.*

SUBSTANCE	PERCENTAGE OF EMPLOYEES EXPOSED	# ACCIDENT REPORTS FILED

LIST OF ATTACHMENTS

A. A nonrefundable application fee of $500, made payable to "Illinois Self-Insurers Administrative Fund."

B. Evidence of applicant's current experience modification factor. Explain if factor is greater than one.

C. An organizational chart showing the hierarchical position of all corporate entities, including the ultimate parent. Note the percentage of ownership and clearly indicate which entity with operations in Illinois is seeking coverage under the certificate of self-insurance.

D. (1) Provide the ultimate parent company's audited financial statements for the most recent year.

(2) If certified audited financial statements are not prepared, provide the financial statements prepared by an outside accountant for the most recent year.

E. Provide the most current 10-Q or internal quarterly balance sheet and income statement of parent.

F. Evidence of the applicant's current workers' compensation coverage. *See question 9.*

G. Detailed Illinois loss runs for the last three completed years. *See question 11.*

H. A narrative description of the safety program components for each operation in Illinois. *See question 12.*

ALL OF THE ABOVE-MENTIONED ITEMS MUST BE SUBMITTED BEFORE A REVIEW OF THE APPLICATION MAY BE COMPLETED.

SUBMISSION OF AN INCOMPLETE APPLICATION MAY DELAY THE REVIEW PROCESS.

APPLICATION FOR SELF-INSURANCE
FOR SUBSIDIARY OR AFFILIATE
AGREEMENTS

In consideration of being granted the privilege of self-insurance under the Illinois Workers' Compensation and Occupational Diseases Acts, the applicant hereby agrees:

1. To promptly pay benefits due to injured employees or their dependents in accordance with the Illinois Workers' Compensation and Occupational Diseases Acts.
2. To promptly report compensable injuries, diseases, and deaths to the Commission as required by law.
3. To promptly notify the Commission of any change in financial condition that will impact the company's ability to self-insure.
4. To immediately notify the Commission before the contemplation of liquidation, sale, or transfer of ownership is made, and to make arrangements satisfactory to the Commission for the payment of all existing liabilities.

This application should be signed and sworn to by the appropriate person or persons as stated below:

if the applicant is an individual, the owner shall sign;
if the applicant is a partnership, all of the partners shall sign;
if the applicant is a corporation, its president or vice-president and its secretary or assistant secretary shall sign.

AFFIDAVIT

State of Illinois

County of _____

Each person listed below, first being sworn on oath, deposes and states that he or she is acquainted with the affairs of this applicant employer, including the representations and statements set forth in this application; that he or she has read said application and all documents submitted, knows their contents, and verifies that the representations and statements are true in substance and in fact.

_____
Applicant's legal name

_____ _____
Signature of affiant and Date Signature of affiant and Date

_____ _____
Name and title of affiant Name and title of affiant

Subscribed and sworn to before me

on _____

_____
Notary public